DDS Statewide Staff Screening for COVID-19

This screening must be completed for all staff coming on duty.
Staff are to report the onset of any symptoms which develop while on duty.

☐ **STS** ☐ **NR** ☐ **SR** ☐ **WR** ☐ Qualified Provider _____

Staff Name: _____ Title: _____

Work Location: _____

Date Last Worked: _____ Temperature Upon Arrival: _____

1. Do you have any of the following unexplained symptoms?

***Fever**	☐ No ☐ Yes
***Cough**	☐ No ☐ Yes
***Difficulty Breathing/Shortness of Breath**	☐ No ☐ Yes

** Indicates the most common symptoms associated with COVID-19, checking "yes" to any of the first three symptoms is not considered as diagnostic for COVID-19; however, employees should be aware of these other related symptoms which should be monitored.*

Vomiting	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes

Comments: _____

_____

If response is "Yes" to any symptoms, please indicate the date of onset (when symptom(s) first occurred):

_____

***If "Yes" to any one, or a combination of the above symptoms <u>may</u> be cause for staff to be sent home and directed not to return until 72-hours with no symptoms, including afebrile (no fever) without taking any fever-reducing medications (i.e., acetaminophen, ibuprofen). It is recommended that staff seek medical attention. A medical note may be required upon return to work.**

RN/Trained Staff Signature: _____ Date: _____ Time _____ ☐AM ☐PM

Print Name: _____

This form shall be maintained in a secure location at the residential facility